Annual Comprehensive Diabetes Foot Exam Form

Name:_____ Date: _____ ID#: _____

I. Presence of diabetes Complications

1. Check all that apply.

- ☐ Peripheral Neuropathy
- ☐ Retinopathy
- ☐ Peripheral Vascular Disease
- ☐ Cardiovascular Disease
- ☐ Amputation (Specify date, side, and level)

Current ulcer or history of a foot ulcer? Y_____ N_____

For Sections II & III, fill in the blanks with "Y" or "N" or with an "R", "L", or "B" for positive findings on the right, left, or both feet.

II. Current History

1. Is there pain in the calf muscles when walking that is relieved by rest? Y_____ N_____
2. Any change in the foot since the last evaluation? Y ___ N ___
3. Any shoe problems? Y ___ N___
4. Any blood or discharge on socks or shoes? Y___N ___
5. Smoking history? Y___ N ___
6. Most recent hemoglobin A1c result _____% _____ *date*

III. Foot Exam

1 Skin, Hair, and Nail Condition

Is the skin thin, fragile, shiny and hairless? Y____N____

Are the nails thick, too long, ingrown, or infected with fungal disease? Y____N____

Measure, draw in, and label the patient's skin condition, using the key and the foot diagram below.

C=Callus U=Ulcer PU=Pre-Ulcer

F=Fissure M=Maceration R=Redness

S=Swelling W=Warmth D=Dryness

2. Note Musculosketletal Deformities

Toe deformities

Bunions (Hallus Valgus)

Charcot foot

Foot drop

Prominent Metatarsal Heads

3. Pedal Pulses Fill in the blanks with a "P" or an "A" to indicate present or absent.

Posterior tibial Left ____Right ____

Dorsalis pedis Left ____Right ____

4. Sensory Foot Exam *Label sensory level with a "+" in the five circled areas of the foot if the patient can feel the 5.07 (10 gram) Semmes-Weinstein nylon monofilament and "-" of the patient cannot feel the filament.*

Notes

Right Foot

Left Foot

Notes

IV. Risk Categorization *Check appropriate box.*

☐ **Low Risk Patient**

All of the following:

- ☐ Intact protective sensation
- ☐ Pedal pulses present
- ☐ No deformity
- ☐ No prior foot ulcer
- ☐ No amputation

☐ **High Risk Patient**

One or more of the following:

- ☐ Loss of protective sensation
- ☐ Absent pedal pulses
- ☐ Foot deformity
- ☐ History of foot ulcer
- ☐ Prior amputation

V. Footwear Assessment *Indicate yes or no.*

1. Does the patient wear appropriate shoes? Y_____ N _____
2. Does the patient need inserts? Y_____ N _____
3. Should corrective footwear be prescribed? Y _____ N _____

VI. Education *Indicate yes or no.*

1. Has the patient had prior foot care education? Y_____ N_____
2. Can the patient demonstrate appropriate foot care? Y_____N_____
3. Does the patient need smoking cessation counseling? Y_____ N_____
4. Does the patient need education about HbA1c or other diabetes self-care? Y_____N _____

VII. Management Plan *Check all that apply:*

1. Self-management education:

Provide patient education for preventive foot care. Date:_____

Provide or refer for smoking cessation counseling. Date:_____

Provide patient education about HbA1c or other aspect of self-care. Date:_____

2. Diagnostic studies:

- ☐ Vascular studies:
- ☐ Hemoglobin A1c (at least twice per year)
- ☐ Other: _____

3. Footwear recommendations:

- ☐ None
- ☐ Athletic shoes
- ☐ Accommodative inserts
- ☐ Custom shoes
- ☐ Depth shoes

4. Refer to:

- ☐ Primary Care Provider
- ☐ Diabetes Educator
- ☐ Podiatrist
- ☐ RN Foot Specialist
- ☐ Pedorthist
- ☐ Orthotist
- ☐ Endocrinologist
- ☐ Vascular surgeon
- ☐ Foot surgeon
- ☐ Rehab. Specialist
- ☐ Other: _____

5. Follow-up Care:

Schedule follow-up visit. Date:

Provider Signature _____